Division of Licensing and Protection
HC 2 South
280 State Drive
Waterbury, VT 05671-2060
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S&C Main Line 802-241-0480
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APS Reporting Line: 1-800-564-1612

February 12, 2016

Ms. Cathy Conley, Manager
Historic Homes Of Runnemede-Stoughton House
40 Maxwell Perkins Lane
Windsor, VT 05089-1206

Dear Ms. Conley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 12, 2016 .** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0161	A. BUILDING: _____ B. WING _____	C 01/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
HISTORIC HOMES OF RUNNEMEDE-STOUGHT	40 MAXWELL PERKINS LANE WINDSOR, VT 05089	FEB 10 2016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensing survey and self-report investigation was conducted on 1/11 - 1/12/16 by the Division of Licensing and Protection. The following are regulatory findings.	R100		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that the written plan of care included all identified needs regarding the use of psychoactive medications for 1 of 6 residents sampled (Resident #1). Findings include: 1. Per record review on 1/11/16, Resident #1 has short term memory problems, and is noted to have episodes of sadness and anxiety. The physician ordered Clonazepam 0.5 mg., one tab by mouth twice daily as needed for weepiness/anxiety. Per review of the plan of care, the section titled "Psychotropic Drug Use" stated there were none. There was no mention of the use of psychotropic medications for this resident in any part of the plan of care. Per interview on 1/11/16 at 1:35 PM, the Charge Nurse confirmed that the use of psychoactive medications was not included in Resident #1's plan of care.	R145	R145 Care plan for Resident #1 updated to reflect use of psychotropic medication. RN co-signing care plans will ensure that all information is accurate at time of signing. RN Administrator will do a random audit of care plans monthly for completeness, accuracy and timeliness of revisions. RN Administrator will provide a report of audits to the QA Committee quarterly and the Board of Directors annually. Mcampt 2.10.16 KCR	2/14/2016 Ongoing ongoing ongoing

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RN Administrator 2/4/2016

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R153	Continued From page 1	R153		
R153 SS=O	V. RESIDENT CARE AND HOME SERVICES 5.9.c (10) Monitor stability of each resident's weight; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that resident weights were monitored regularly for 2 of 6 residents sampled (Resident #1, #2). Findings include: 1. Per record review on 1/11/16, Resident #1 had a monthly weight recorded as 138 lb. on 8/1/15. There was no monthly weight recorded in September 2015. The weight recorded on 10/1/15 was 134.2, an over 3 lb. weight loss since August. On 11/1/15, the resident's weight was recorded as 119 lbs., which is a 15 lb. difference from the 10/1/15 weight. There was no weight recorded for December 2015. There was no evidence that staff had reweighed the resident for confirmation of the accuracy of the reading after the weight was so significantly lower, or that nursing recognized and intervened to determine if nutritional or other interventions would help to stabilize the weight loss. Per interview on 1/11/16 at 4:05 PM, the Charge Nurse confirmed that this resident was weighed today and has not had a significant weight loss, and that the reading on 11/1/15 was probably an error, however staff did not bring this to the attention of nursing. The nurse confirmed at this time also that the monthly weights were not recorded for September and December of 2015. 2. Per record review on 1/11/16, Resident #2 had	R153	R153 New form developed which lists all residents and will provide 6 months of weights at a glance. This form will be kept in the front of the MAR. Staff education on use of form will occur at monthly staff meeting. Use of form instituted Charge Nurse will review form the 3rd week of each month to verify completion of weights and allow for adequate notice to staff of weights needing completion. For those on weekly weights the Charge Nurse will verify completion of task on Thursdays to allow for adequate notice to staff if not yet completed. RN Administrator will monitor for completion of weights as ordered and work with Charge Nurse to develop/review any plans to address significant weight changes, monthly. Acceptable 2.10.16 KC/SL	1/14/16 1/20/16 ongoing ongoing ongoing

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R153	Continued From page 2 a weight documented at admission on 3/31/15 of 144.6 lbs. In April 2015, the resident was put on weekly weight monitoring after a 3 lb. weight loss since March 2015. Per review of the record, there were no weights recorded for the months of May or June 2015. In July 2015 a weight was recorded of 135 lbs. This showed a 6 lb. weight loss since admission. There were no weights documented in August or September 2015. In October 2015, the resident's weight was documented at 135 lbs, showing that this had stabilized. There was also no documentation of any interventions initiated, or an update to the plan of care. Per interview on 1/11/16 at 4:05 PM, the Charge Nurse confirmed that there was missing weight documentation for Residents #1, and #2 for the above months listed, and that these residents had lost weight. The nurse stated that they were not aware of the missing weight documentation for these residents, and had been counting on the direct care staff who weigh the residents to alert nursing to concerns.	R153	R153 (con't.) Charge Nurse will report on weight management to the QA committee quarterly. RN Administrator will report on weight management to the Board of Directors, annually.	ongoing ongoing
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the	R167	R167 New form to be put in place for each resident with an order for PRN psychoactive medications. This form will be resident specific and will state behaviors to be addressed as well as, non-pharmacologic interventions to try prior to administering the medication. Possible medication side effects will also be listed. This will be kept in the MAR. Revised 2.10.16 KCLL	2/29/2016

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R167	Continued From page 3 staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that there was a written plan for non-nursing staff administering PRN (as needed) psychoactive medications for one resident sampled (Resident #1). Findings include: 1. Per record review on 1/11/16, Resident #1 has short term memory problems, and is noted to have episodes of sadness and anxiety. The physician ordered Clonazepam 0.5 mg., one tab by mouth twice daily as needed for weepiness/anxiety. Per review of the plan of care, the section titled "Psychotropic Drug Use" stated there were none. There was no written plan for the non-nursing staff for the appropriate use of psychotropic medication that included the specific behaviors or circumstances , the side effects to be monitored, and documentation of the effectiveness of the medication. Per interview on 1/11/16 at 1:35 PM, the Charge Nurse confirmed that the resident did not have a written plan for non-nursing staff for the use of the PRN psychoactive medication.	R167	R167 (con't.) An initial form is to be completed within 48 hours of admission (or with new order) and reviewed / revised at the time of completion of the Resident Assessment. Forms will be reviewed with each Care Plan review and prn. Forms to be signed by Charge Nurse and RN Administrator. Charge Nurse will monitor for proper documentation of any medication administration / interventions tried, monthly. Charge Nurse will provide report to the QA committee quarterly and RN Administrator to the Board of Directors annually. Education of form / documentation will be provided to staff at monthly staff meeting. (Documenting will occur in PCA notes).	ongoing ongoing ongoing ongoing ongoing 2/11/2016

POC rec'd 2.10.16 KC/CA